Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing

Tuesday 18 April 2023 to Friday 21 April 2023; Monday 24 April 2023 to Friday 28 April 2023; Tuesday 2 May 2023 to Friday 5 May 2023; Tuesday 9 May 2023 to Thursday 11 May 2023 and Thursday 7 September 2023

Virtual Hearing

Name of Registrant:	**Amanda Jane Callon**
NMC PIN	06B1511E
Part(s) of the register:	Nursing, Sub part 1 RNA, Registered Nurse – Adult (27 March 2006)
Relevant Location:	Burnley
Type of case:	Misconduct
Panel members:	Adrian Blomefield (Chair, Lay member) Jonathan Coombes (Registrant member) Alison Hayle (Lay member)
Legal Assessor:	Andrew Young
Hearings Coordinator:	Petra Bernard
Nursing and Midwifery Council:	Represented by Sophie Quinton-Carter (of Counsel), Case Presenter
Miss Callon:	Not present and not represented
No case to answer:	Charges 18.1 (part), 18.2 (part), 20.2
Facts proved:	Charges 1.1, 1.2.1, 1.2.2, 1.2.3, 1.3, 1.4, 1.5, 1.6, 2, 3, 5.1, 6.1, 7.1, 7.2, 7.3, 7.4, 8.1, 8.2, 8.3, 9.1, 9.2, 11.1, 11.2, 13.2, 14.1, 14.2, 17, 18.1 (part), 18.2 (part), 18.3, 20.1, 21, 22.1, 22.2, 23, 24.1, 24.2, 25, 30.2

Facts not proved:	Charges 4.1, 4.2, 4.3, 5.2, 6.2, 10.1, 10.2, 12.1, 12.2, 13.1, 18.4, 18.5, 19, 26, 27, 29, 31
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Miss Callon was not in attendance and that the Notice of Hearing letter had been sent to her registered email address by secure email on 20 March 2023.

Miss Quinton-Carter, on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegations, the time, dates and that the hearing was to be held virtually. The notice also included instructions on how to join and, amongst other things, information about Miss Callon's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

In the light of all of the information available, the panel was satisfied that Miss Callon has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Miss Callon

The panel next considered whether it should proceed in the absence of Miss Callon. It had regard to Rule 21 and heard the submissions of Miss Quinton-Carter who invited the panel to continue in the absence of Miss Callon. She submitted that Miss Callon had voluntarily absented herself.

Miss Quinton-Carter submitted that there had been no engagement by Miss Callon with the NMC since 19 April 2022 in relation to these proceedings and, as a consequence, there was no reason to believe that an adjournment would secure her attendance on

some future occasion. She referred the panel to a telephone note made on 19 April 2022 by Miss Callon's NMC case officer, in which it notes that Miss Callon stated:

> *'...that she had received it [the case management] but hasn't completed it yet and doesn't think she will. She has provided a statement previously so was not sure why we needed this to*
>
> *...*
>
> *She said she does dispute the issues raised but she's not able to engage with the proceedings and just wants the case to be over. She has no plans to return to nursing and has not renewed her registration.'*

The panel accepted the advice of the legal assessor. He referred the panel to the cases of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5 and to the *General Medical Council v Adeogba* [2016] EWCA Civ 162 as relevant case law.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'* as referred to in the case of *R v Jones.*

The panel has decided to proceed in the absence of Miss Callon. In reaching this decision, the panel has considered the submissions of Miss Quinton-Carter and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and to *GMC v Adeogba* and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Miss Callon;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- A number of witnesses are due to attend during the course of the hearing to give live evidence;

- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred five years ago, further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case and it is in the interest of Miss Callon and the NMC for the case to proceed.

There is some disadvantage to Miss Callon in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered email address, she has made no response to the allegations except in response to the case management form. Additionally, she will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Further, any disadvantage would be the consequence of Miss Callon's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

In these circumstances, the panel has decided that it is fair to proceed in the absence of Miss Callon. The panel will draw no adverse inference from Miss Callon's absence in its findings of fact.

Details of charges (Original)

That you, a Registered Nurse:

1. On the night shift of 28 July 2018:

1.1 Wrote a prescription of morphine as a single dose Patient A's inpatient prescription chart or amended the prescription chart to add the date and/or the word 'nocte', when you were not qualified to do so.
1.2. Administered morphine to Patient A when it was not clinically justified in that:
1.2.1 You did not carry out any, or any sufficient, assessment of patient A's pain needs;
1.2.2 You did not consult a doctor
1.2.3 You did not first administer a milder analgesia.
1.3 Failed to record in Patient A's notes the reason for administration of morphine on the night shift of 28 July 2018.
1.4 Failed to record the time the morphine was administered to Patient A on the night shift on the prescription sheet.
1.5 Tore up Patient A's inpatient prescription chart.
1.6 Put Patient A's torn inpatient prescription chart in the confidential waste bin on Ward B4.

2. Your actions at charge 1.1 1 were dishonest in that you were by so doing representing that morphine had been properly prescribed or the prescription properly amended.

3. Your actions at charge 1.5 and/or 1.6 were dishonest in that you sought to conceal that you had had written or amended the prescription.

4. Administered morphine to Patient F on 11.01.2018 at about 21:30 and/or 12.01.2018 at about 21:00 when it was not clinically justified in that:
4.1 You did not carry out any, or any sufficient, assessment of patient F's pain needs;
4.2 You did not administer a milder analgesia first;
4.3 All doses of morphine received by Patient F on Ward B4 were given under your care.

5 Failed to record in Patient F's notes a rationale in Patient F's notes for the administration of morphine on one or more of the following occasions:

5.1 11/01/2018 at about 9:30pm;
5.2 12/01/2018 at about 9pm.

6. Failed to record the administration of morphine to Patient F in the nursing notes on one or more of the following occasions:
6.1 On 11/01/2018 at about 9:30pm;
6.2 On 12/01/2018 at about 9pm;

7. Administered morphine to Patient D when it was not clinically justified in that you did not carry out any, or any sufficient, assessment of D's pain needs on one or more of the following occasions:
7.1 15 May 2018 at about 23:10;
7.2 16 May 2018 at about 04:30;
7.3. 17 May 2018 at about 01:30;
7.4 31 May 2018 at about 00:35.

8. Did not record a reason for the administration of morphine to Patient D on one or more of the following occasions:
8.1 16 May 2018 at about 04:30;
8.2 17 May 2018 at about 01:30;
8.3 31 May 2018 at about 00:35

9 Did not record the administration of morphine to Patient D in the patients notes on one or more of the following occasions:
9.1 17 May 2018 at about 01:30
9.2 31 May 2018 at about 00:35

10 Administered morphine to Patient E when it was not clinically justified to do so in that you did not carry out or record any, or any sufficient, assessment of Patient E's pain needs on one or more of the following occasions:
10.1 11 April 2018 at about 21:45
10.2 12 April 2018 at about 02:25

11. Did not record the administration of morphine to Patient E in the patients' notes on one or more of the following occasions:
11.1 11 April 2018 at about 21:45 with respect to the dose;
11.2 12 April 2018 at about 02:25.

12 Administered morphine to Patient G at about 23:45 on 5 March 2018 when it was not clinically justified in that:
12.1 There was no prescription recorded on the patient's drug chart
12.2 You did not carry out or record, any, or any sufficient assessment of Patient G's pain needs.

13 Did not record in Patient G's notes
13.1 a rationale for the administration of morphine at charge 12.
13.2 the administration of morphine at charge 12

14 Administered morphine to Patient I on 4 June 2018 when it was not clinically justified in that:

15.1 You did not carry out, or record any, or any sufficient assessment of Patient I's pain needs.
16.2 You did not administer a milder analgesia before administering the morphine.

17. Failed to record in Patient I's nursing notes that morphine had been administered on 4 June 2018.

18. In relation to Patient C:
18.1 Failed to document a pain score and/or a rationale for administering morphine on 22 July 2018 at about 05:00 and/or about 23:10.
18.2 Failed to record the administration of morphine at about 05:00 and/or about 23:10 on 22 July 2018 in the patient notes.
18.3 Failed to record why it was necessary to call a doctor to prescribe morphine on 22 July 2018.

18.4 Failed to administer the prescribed paracetamol and/or co-codamol before administering morphine.
18.5 Failed to dispose of the ampule of morphine into the sharps bin.

19 On an unknown date in July 2018, after administering morphine to Patient failed to dispose of the wastage/ampule in the sharps bin.

20 Administered morphine to Patient H on 25 December 2017 when it was not clinically justified in that:
20.1 You did not carry out, and/or record any assessment, or any adequate assessment, of the patient's pain needs;
20.2 There was no morphine dose on the patient's drug chart.

21 Failed to record in Patient H's nursing notes that morphine had been administered on 25 December 2017.

22 Administered morphine to Patient J on 9 June 2018 when it was not clinically justified in that:
22.1 You did not carry out, and/or record any assessment, or any adequate assessment, of the patient's pain needs.
22.2 You did not administer a milder analgesia before administering the morphine.

23 Failed to record in Patient J's nursing notes that morphine had been administered on 9 June 2018.

24 Recorded in the Controlled drugs book that the morphine booked out for patient J on 9 June 2018 was an injectable dose to be administered subcutaneously when:
24.1 It was prescribed to be taken orally;
24.2 It was recorded on the prescription chart as being given by the oral route.

25 Failed to record the administration of morphine to Patient B at approximately 04:45 on 19 July 2018 on the prescription chart.

26 On 17 July 2018 administered morphine to Patient B when it was not clinically justified to do so in that you did not carry out and/or record any or any adequate assessment of Patient B's pain needs:

27. Failed to document the administration of morphine to Patient B in the nursing notes on 17 July 2018.

28 Did not record the administration of morphine to Patient B at approximately 04:45 on 19 July 2018 on the medication/prescription chart.

29. Administered morphine to Patient K on 18 July 2018 when it was not clinically justified in that there was not a clear clinical indication that morphine was required.

30. On unknown dates in or around 2018 wrote and/or amended part or parts of one or more of the following prescriptions or purported prescriptions:
30.1 A prescription or for Patient A dated 28 July 2018
30.2 A prescription for Patient F dated 11 January

31. Your actions at charge 30 above were dishonest in that you intended that one or more of those parts appear to be written by someone else and/or to be genuine parts of a prescription, when you knew they were not.

AND in light of the above, your fitness to practise is impaired by reason of your misconduct.

Decision and reasons on application to amend the charge (Day one)

The panel heard an application made by Miss Quinton-Carter, on behalf of the NMC, to amend the wording, correct spelling, delete duplicate charges and to correct the number

chronology of the preamble to the charges and to charges 1.1, 2, 3, 7, 15.1, 16.2, 19, 28, 30.1 and 30.2.

Miss Quinton-Carter submitted that the proposed amendment would provide clarity and more accurately reflect the evidence.

Details of charges (As amended and read)

That you, a Registered Nurse **whilst working at the Royal Blackburn Hospital:**

1. On the night shift of 28 July 2018:
1.1 Wrote a prescription of morphine as a single dose **on** Patient A's inpatient prescription chart or amended the prescription chart to add the date and/or the word 'nocte', when you were not qualified to do so.
1.2. Administered morphine to Patient A when it was not clinically justified in that:
1.2.1 You did not carry out any, or any sufficient, assessment of patient A's pain needs;
1.2.2 You did not consult a doctor
1.2.3 You did not first administer a milder analgesia.
1.3 Failed to record in Patient A's notes the reason for administration of morphine on the night shift of 28 July 2018.
1.4 Failed to record the time the morphine was administered to Patient A on the night shift on the prescription sheet.
1.5 Tore up Patient A's inpatient prescription chart.
1.6 Put Patient A's torn inpatient prescription chart in the confidential waste bin on Ward B4.

2. Your actions at charge 1.1 ~~1~~ were dishonest in that you were by so doing representing that morphine had been properly prescribed or the prescription properly amended.

3. Your actions at charge 1.5 and/or 1.6 were dishonest in that you sought to conceal that you ~~**had**~~ had written or amended the prescription.

4. Administered morphine to Patient F on 11.01.2018 at about 21:30 and/or 12.01.2018 at about 21:00 when it was not clinically justified in that:
4.1 You did not carry out any, or any sufficient, assessment of patient F's pain needs;
4.2 You did not administer a milder analgesia first;
4.3 All ~~does~~ **doses** of morphine received by Patient F on Ward B4 were given under your care.

5 Failed to record in Patient F's notes a rationale in Patient F's notes for the administration of morphine on one or more of the following occasions:
5.1 11/01/2018 at about 9:30pm;
5.2 12/01/2018 at about 9pm.

6. Failed to record the administration of morphine to Patient F in the nursing notes on one or more of the following occasions:
6.1 On 11/01/2018 at about 9:30pm;
6.2 On 12/01/2018 at about 9pm;

7. Administered morphine to Patient D when it was not clinically justified in that you did not carry out any, or any sufficient, assessment of **Patient** D's pain needs on one or more of the following occasions:
7.1 15 May 2018 at about 23:10;
7.2 16 May 2018 at about 04:30;
7.3. 17 May 2018 at about 01:30;
7.4 31 May 2018 at about 00:35.

8. Did not record a reason for the administration of morphine to Patient D on one or more of the following occasions:
8.1 16 May 2018 at about 04:30;
8.2 17 May 2018 at about 01:30;

8.3 31 May 2018 at about 00:35

9 Did not record the administration of morphine to Patient D in the ~~patients notes~~ **nursing notes** on one or more of the following occasions:
9.1 17 May 2018 at about 01:30
9.2 31 May 2018 at about 00:35

10 Administered morphine to Patient E when it was not clinically justified to do so in that you did not carry out or record any, or any sufficient, assessment of Patient E's pain needs on one or more of the following occasions:
10.1 11 April 2018 at about 21:45
10.2 12 April 2018 at about 02:25

11. Did not record the administration of morphine to Patient E in the ~~patients' notes~~ **nursing notes** on one or more of the following occasions:
11.1 11 April 2018 at about 21:45 with respect to the dose;
11.2 12 April 2018 at about 02:25.

12 Administered morphine to Patient G at about 23:45 on 5 March 2018 when it was not clinically justified in that:
12.1 There was no prescription recorded on the patient's drug chart
12.2 You did not carry out or record, any, or any sufficient assessment of Patient G's pain needs.

13 Did not record in Patient G's ~~notes~~ **nursing notes**
13.1 a rationale for the administration of morphine at charge 12.
13.2 the administration of morphine at charge 12

14 Administered morphine to Patient I on 4 June 2018 when it was not clinically justified in that:
~~15.1~~ **14.1** You did not carry out, or record any, or any sufficient assessment of Patient I's pain needs.

~~16.2~~ **14.2** You did not administer a milder analgesia before administering the morphine.

17. Failed to record in Patient I's nursing notes that morphine had been administered on 4 June 2018.

18. In relation to Patient C:
18.1 Failed to document a pain score and/or a rationale for administering morphine on 22 July 2018 at about 05:00 and/or about 23:10.
18.2 Failed to record the administration of morphine at about 05:00 and/or about 23:10 on 22 July 2018 in the ~~patient notes~~ **nursing notes**.
18.3 Failed to record why it was necessary to call a doctor to prescribe morphine on 22 July 2018.
18.4 Failed to administer the prescribed paracetamol and/or co-codamol before administering morphine.
18.5 Failed to dispose of the ampule of morphine into the sharps bin.

19 On an unknown date in July 2018, after administering morphine to Patient **M** failed to dispose of the wastage/ampule in the sharps bin.

20 Administered morphine to Patient H on 25 December 2017 when it was not clinically justified in that:
20.1 You did not carry out, and/or record any assessment, or any adequate assessment, of the patient's pain needs;
20.2 There was no morphine dose on the patient's drug chart.

21 Failed to record in Patient H's nursing notes that morphine had been administered on 25 December 2017.

22 Administered morphine to Patient J on 9 June 2018 when it was not clinically justified in that:
22.1 You did not carry out, and/or record any assessment, or any adequate assessment, of the patient's pain needs.

22.2 You did not administer a milder analgesia before administering the morphine.

23 Failed to record in Patient J's nursing notes that morphine had been administered on 9 June 2018.
24 Recorded in the Controlled drugs book that the morphine booked out for patient J on 9 June 2018 was an injectable dose to be administered subcutaneously when:
24.1 It was prescribed to be taken orally;
24.2 It was recorded on the prescription chart as being given by the oral route.

25 Failed to record the administration of morphine to Patient B at approximately 04:45 on 19 July 2018 on the prescription chart.

26 On 17 July 2018 administered morphine to Patient B when it was not clinically justified to do so in that you did not carry out and/or record any or any adequate assessment of Patient B's pain needs~~;~~

27. Failed to document the administration of morphine to Patient B in the nursing notes on 17 July 2018.

~~28, Did not record the administration of morphine to Patient B at approximately 04:45 on 19 July 2018 on the medication/prescription chart.~~

29. Administered morphine to Patient K on 18 July 2018 when it was not clinically justified in that there was not a clear clinical indication that morphine was required.

30. On **an** unknown ~~dates~~ **date** in or around 2018 wrote and/or amended part or parts of one or more of the following prescriptions or purported prescriptions:

~~30.1 A prescription or for Patient A dated 28 July 2018~~

30.2 A prescription for Patient F dated 11 January **2018**

31. Your actions at charge 30 above were dishonest in that you intended that one or more of those parts appear to be written by someone else and/or to be genuine parts of a prescription, when you knew they were not.

AND in light of the above, your fitness to practise is impaired by reason of your misconduct.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel determined that the amendments, as applied for, would provide more clarity and would more accurately reflect the evidence. The panel was satisfied that there would be no prejudice to Miss Callon and no injustice would be caused to either party by the proposed amendments being allowed. It was therefore appropriate to allow the amendments, as applied for, to ensure clarity and accuracy.

Consideration of no case to answer

In relation to the issue of no case to answer, the panel heard and accepted the advice of the legal assessor, who referred the panel to Rule 24(7) of the NMC (Fitness to Practise) Rules 2004, It provides that, except where all the facts have been admitted and found proved, at the close of the NMC case, the panel may, either on the registrant's application or of its own volition, hear submissions from the parties as to whether sufficient evidence has been presented to find the facts proved and shall make a determination as to whether the registrant has a case to answer.

In this case, Miss Callon is not present or represented, but it remains open to the panel to raise the issue of no case to answer of its own volition in relation to some parts of the Schedule of Charges in the light of the evidence presented during the hearing.

The test to be applied in deciding whether there is a case to answer in respect of any of the charges is set out in the criminal case of *R v. Galbraith* (1981) 72 CAR 124, where the Court of Appeal gave the following guidance:

> *'(1) If there is no evidence that the crime alleged has been committed by the defendant there is no difficulty – the judge will stop the case.*
>
> *(2) The difficulty arises where there is some evidence but it is of a tenuous character, for example, because of inherent weakness or vagueness or because it is inconsistent with other evidence.*
>
> > *(a) Where the judge concludes that the prosecution evidence, taken at its highest, is such that a jury properly directed could not properly convict on it, it is his duty, on a submission being made, to stop the case.*
> >
> > *(b) Where however the witness's reliability, or other matters which are generally speaking within the province of the jury and where on one possible view of the facts there is evidence on which the jury could properly come to the conclusion that the defendant is guilty, then the judge should allow the matter to be tried by the jury.'*

In this case, the panel took the view that there are certain parts of certain charges in relation to which it might find that there is no case to answer. This is on the basis that some of the necessary documents which would have to be scrutinised by it in order to establish facts are not in the exhibit bundle, or that there are inconsistencies in the NMC evidence which will make it impossible to find the facts proved on a balance of probabilities.

It was open to the panel to consider other parts of the Schedule of Charges, but the panel took the view that Miss Callon may not have a case to answer in relation to the following parts of the Schedule of Charges:

Charge 12.1: On the basis that Patient G's drug chart has not been provided in evidence by the NMC, either as part of Exhibit PK16 (p.1120-1132) or elsewhere, so it is impossible for the panel to determine whether there was a prescription for morphine on Patient G's drug chart.

Charge 18.1 and 18.2: Insofar as they relate to an administration of morphine to Patient C at about 05:00 on 22 July 2018 on the basis that the care notes relating to Patient C provided by the NMC (at p.1069-70) start at 13:30 on 22.07.2018 and do not include notes relating to the period when an administration of morphine at 05:00 would have documented in Patient C's care notes.

Charge 20.2: In light of the fact that the drug chart that has been provided in evidence by the NMC (at p.1363-4 as part of exhibit VG13) states in the margin at p.1364 that *'lost drug chart replaced'* and the chart that has actually been produced states on p.1363 that it was started on 26 December 2018, so it may be impossible for the panel to determine whether any morphine was administered to Patient H on 25.December 2018, even if a dosage of the drug is recorded as having been withdrawn from the controlled drugs book.

NMC submissions on no case to answer

The panel took account of the submissions made by Miss Quinton-Carter.

In relation to Charge 12.1, Miss Quinton-Carter submitted that in Witness 14's statement, she indicated that the prescription chart could not be located. However, she said it is not a requirement, either evidentially or legally, to provide the original document if it cannot be located. Further its absence does not mean that there is no case to answer, provided a witness can give evidence that they have seen the document in question as to its contents.

Miss Quinton-Carter referred the panel to Witness 8's statement and his live evidence where it was made clear that he had asked questions about each of the patients during the course of the disciplinary hearing in 2019 and she submitted that it is indicated in his

statement that he did have sight of the document in question at the time of the disciplinary hearing in 2019.

Miss Quinton-Carter submitted that it is the NMC's position that questions were asked and answered about the prescription chart in question, and that it has been lost or unable to be located in the intervening time between Miss Callon's disciplinary hearing in 2019 and the NMC's subsequent investigation. She submitted that if the panel is concerned that the chart was in fact lost at the time of the investigation, and that the evidence heard is either open to confusion or may be unreliable, the right course would be to recall Witness 14 in order to clarify the situation.

In these circumstances, Miss Quinton-Carter submitted that this charge should be allowed to remain before the panel.

In relation to Charges 18.1 and 18.2, Miss Quinton-Carter submitted that the NMC cannot identify evidence relating to the 5:00am aspect of both charges, as the care notes provided by the Trust to not cover the shift in question, nor do any of the witness statements deal with this aspect of the charge. Therefore, she submitted that it is conceded that there is no further evidence relating to this aspect of the charges that the NMC can point to in support of these charges. She submitted that the panel is still invited to make findings on these two charges in respect of the 23:10 morphine administration.

In these circumstances, Miss Quinton-Carter did not oppose a decision by the panel that there was no case to answer in respect of the morphine administration to Patient C at about 05:00 on 22 July 2018 but she submitted that charges 18.1 and 18.2 should be allowed to remain before the panel in respect of the morphine administration at about 23:10 on 22 July 2018.

In relation to charge 20.2, Miss Quinton-Carter submitted that Witness 14 had indicated in her live evidence that a morphine prescription had not been on the admissions documentation for Patient H, and this was documentation considered as part of the Trust's investigation. She submitted that in Witness 14's live evidence she stated that if

the Doctor who was part of the admission process was prescribing morphine, then it would be included in the admission details for that patient. It wasn't in there for this patient.

Miss Quinton-Carter submitted that the earlier submission made regarding the provision of the original chart itself is repeated in respect of this particular charge. She submitted that there is no ground to suggest that there was a transcription error in the replacement chart dated the 26 December 2018, and that no questions had been advanced to any of the witnesses during the course of these proceedings.

In relation to the suggestion that there may have been an error in completing the replacement chart, Miss Quinton-Carter submitted that it is merely speculative to suggest this. She referred the panel to the exhibit which shows some medications were reproduced on the replacement chart.

Miss Quinton-Carter submitted that there is no evidence that morphine was ever prescribed to Patient H. When taking that, together with Witness 14’s statements that morphine is not prescribed for patients with pneumonia due to the potential impact on respiratory rate, Miss Quinton-Carter submitted that the panel could conclude that there is a case to answer and that there was no morphine dose on Patient H’s drug chart.

In these circumstances, Miss Quinton-Carter submitted that this charge should be allowed to remain before the panel.

Decision and reasons on no case to answer

In reaching its decision, the panel has made an initial assessment of all the evidence that had been presented to it at this stage. The panel was solely considering whether sufficient evidence had been presented, such that it could find the facts proved and whether Miss Callon had a case to answer.

In relation to charge 12.1, the panel had regard to the submissions made Miss Quinton-Carter and all of the oral and documentary evidence in relation to the circumstances on

5 March 2018. The panel accepted that there was reference to the drugs chart at the time of Miss Callon's disciplinary investigation and in Witness 8's statements and therefore the panel took the view that it was appropriate to consider the charge.

The panel was of the view that there had been sufficient evidence to support charge 12.1 at this stage and, as such, it was not prepared, based on the evidence before it, to conclude there is no case to answer. What weight the panel gives to any evidence remains to be determined at the conclusion of all the evidence.

The panel was of the view that, taking account of all the evidence before it, there was not a realistic prospect that it would find the facts of 18.1 (partially), 18.2 (partially) and 20.2 found proved.

In relation to Charges 18.1 and 18.2, insofar as they referred to an administration of morphine at about 05:00 to Patient C on 22 July 2018, the panel noted that Miss Quinton-Carter conceded that there was no evidence before the panel in the care notes for Patient C, indicating that this administration of morphine had taken place. The relevant care notes start at 13:30 on 22 July 2018 and no earlier care notes have been put before the panel. Miss Quinton-Carter further conceded that there is no other evidence to support this part of these two Charges. Therefore, the panel concluded that there is no case to answer in respect of the 05:00 administration of morphine in both of these charges.

In relation to charge 20.2, the panel had regard to the submissions made by Miss Quinton-Carter and all of the oral and documentary evidence in relation to Patient H on 25 December 2017. The panel had asked Witness 14 if her investigation had identified the second checker on the controlled drugs book for this dose, and if that checker had seen a prescription. Witness 14 confirmed that the second checker had been identified and had stated that they had seen a prescription for morphine on Patient H's chart. However, the investigation had been unable to identify who had written this prescription. The panel had also asked Witness 14 if any investigation into the loss of the chart had been carried out, but Witness 14 could not recall.

The panel further determined that had a one-off prescription for morphine been on the original chart for 25 December 2017, there would have been no reason for this to be transcribed to the new chart on 26 December 2017. The panel noted that the new chart contains only prescriptions for regular medication. The panel was also concerned about placing reliance on the admissions documentation in relation to Patient H which it has not seen.

For all these reasons and given the fact that the earlier drug chart for Patient H, which covers the date of the charge, namely 25 December 2017, has not been produced to enable the panel to establish whether it included a prescription for morphine or not, the panel determined that there is no case to answer in respect of this charge.

Decision and reasons on application to amend charges (Day fourteen)

At the start of the hearing on 9 May 2023, the panel heard an application made by Miss Quinton-Carter, on behalf of the NMC, to amend the wording to charges 9.1, 9.2, 11.1, 13.2 and 18.2.

Miss Quinton-Carter submitted that the proposed amendments would provide clarity and more accurately reflect the evidence and she further submitted that the proposed amendments would cause no prejudice to Miss Callon and that they are simply omissions in the way the charges have been written.

Details of charges (As amended)

9 Did not record the administration of morphine to Patient D in the ~~patients notes~~ **nursing notes** on one or more of the following occasions:
9.1 17 May 2018 at about 01:30
9.2 31 May 2018 at about 00:35

11. Did not record the administration of morphine to Patient E in the ~~patients' notes~~ **nursing notes** on one or more of the following occasions:
11.1 11 April 2018 at about 21:45 with respect to the dose;

13 Did not record in Patient G's ~~notes~~ **nursing notes**

13.2 the administration of morphine at charge 12

18. In relation to Patient C:
18.2 Failed to record the administration of morphine at about 05:00 and/or about 23:10 on 22 July 2018 in the ~~patient notes~~ **nursing notes**.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel determined that the amendments, as applied for, would provide clarity and would remove an uncertainty from some of the charges. The panel was satisfied that there would be no prejudice to Miss Callon and no injustice would be caused to either party by the proposed amendments being allowed. It was therefore appropriate to allow the amendments, as applied for, to ensure clarity and accuracy.

The panel is of the view that the NMC has presented its case and questioned witnesses and represented in their submissions that the documents referred to in these charges would have been the patient care notes. The panel were of the view that that the allegations are essentially the same and as the NMC have said it is a case of omission in the way the charges are written.

The panel determined that the clarity which the proposed amendments bring is helpful to the panel but also to anyone reading the determination. The panel did not consider that there would be any injustice to the Miss Callon on the basis that should she have been present and represented and amendments were sought by the NMC the panel would have accepted those amendments at the time.

The panel notes that an application to amend charge 11.1 is consistent with the other applications and the NMC in its submissions has conceded that in order to be consistent it may be that the panel determines that charge 11.1 falls away.

The panel also had regard to the registrant's response bundle in which she accepts the regulatory concern in relation to documentation and record keeping.

Background

Miss Callon was referred to the NMC on 27 August 2019 by East Lancashire Hospitals NHS Trust (the Trust) where she was employed as a Staff Nurse at the Royal Blackburn Hospital (the Hospital).

On 28 July 2018, a colleague was concerned that a patient, allegedly under Miss Callon's care, had received a dose of injectable morphine. The reason for the administration was not documented in the nursing notes and the prescription chart was missing. The dose had been signed as administered in the controlled drug register administration records on 28 July 2018. The missing patient's prescription chart was later found torn up in the confidential waste bin. This chart allegedly contained a prescription for a single dose of morphine but was not signed for as administered by Miss Callon.

Following other findings that emerged during the internal investigation, the scope of the investigation was widened to look at the administration of morphine to other patients under Miss Callon's care.

Miss Callon resigned from her position on 5 August 2019, the day before her scheduled disciplinary hearing. The Trust proceeded with the hearing in Miss Callon's absence and decided that it would have summarily dismissed her for gross misconduct had she not resigned.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Miss Quinton-Carter.

The panel accepted the advice of the legal assessor who referred the panel to the relevant case law, including *Ivey v Genting Casinos Ltd t/a Crockfords* [2017] UKSC 67 on the issue of dishonesty.

The panel has drawn no adverse inference from the non-attendance of Miss Callon.

The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that a fact will be found proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the witness and documentary evidence provided by the NMC and Miss Callon's statements in her response form.

The panel heard live evidence from the following witnesses called on behalf of the NMC:

- Witness 1: Staff Nurse at the Hospital on ward B4, at the relevant time;
- Witness 2: Matron at the Hospital covering ward B4, at the relevant time.
- Witness 3 Expert Witness, Forensic Handwriting & Document Examiner
- Witness 4 Ward Sister at the Hospital on Ward B4, at the relevant time
- Witness 5 Staff Nurse at the Hospital on Ward B4, relevant time

- Witness 6: Assistant Director of Pharmacy for Clinical Services for the East Lancashire Hospitals NHS Hospital ("the Hospital 2) and internal investigator at the relevant time
- Witness 7: Doctor at the Hospital on Ward B4 at the relevant time
- Witness 8: Chair of Miss Callon's disciplinary hearing on 6 August 2019 at the relevant time
- Witness 9: Staff nurse at the Hospital on Ward B2, at the relevant time
- Witness 10: Registered General Nurse at the Hospital on Ward B2 at the relevant time
- Witness 11: Registered Nurse at the Hospital on Ward B2 as a night shift bank nurse at the relevant time
- Witness 12: Registered Nurse at the Hospital, covered a shift on Ward B4 at the relevant time
- Witness 13 Band 6 Ward Sister at the Hospital on Ward B4 at the relevant time

- Witness 14: Matron at the Trust and Investigating Manager at the Hospital at the relevant time

Panel considerations on case presentation

Throughout the presentation of evidence and during the fact-finding stage, the panel was asked to decide whether Miss Callon had carried out, and/or recorded any assessment, or any adequate assessment, of patients pain needs. The panel has documented its decisions under each charge appropriately.

A uniform approach was taken by the panel regarding references to *"pain scores"* when this term was referred to in evidence. Witness 14 informed the panel that pain scores are usually recorded on Observation charts and sometimes recorded on patient care notes. The documentary evidence from the NMC did not include any observation charts but the panel heard from Witness 14 that during the internal investigation she reviewed all of the observation charts for the patients relating to the charges against Miss Callon and no pain scores were recorded by Miss Callon in any of them. The notes of the disciplinary meeting 6 August 2019 include questions from Witness 8 who chaired the disciplinary meeting and asked of witness 14 for each patient *"was there a documented pain score?"* and in each case the answer was no. Therefore, the panel has relied on this combination of oral and written evidence that no pain scores were recorded by Miss Callon for any of the patients referenced in the charges against her.

For the avoidance of doubt, the panel has in certain places used the term 'patient care notes' in its reasoning in the determination which follows, instead of the term 'nursing notes', but the first term should be regarded as referring only to nursing notes and not to any other documentation.

The panel then considered each of the disputed charges and made the following findings.

That you, a Registered Nurse whilst working at the Royal Blackburn Hospital:

Charge 1

1. On the night shift of 28 July 2018:
1.1 Wrote a prescription of morphine as a single dose on Patient A's inpatient prescription chart or amended the prescription chart to add the date and/or the word 'nocte', when you were not qualified to do so.

This charge is found proved

In reaching this decision, the panel took account of the written statements and oral evidence of Witness 3, Witness 6 and Witness 14. Witness 3, a handwriting expert, testified that the word *'nocte'* was written by Miss Callon. The prescription for morphine on patient A's prescription chart was entirely in her handwriting although he cannot be certain the signature was in her writing.

In Witness 6's evidence, he explained how the internal investigation tried to identify who had signed the prescription. He stated that no non-medical prescriber would have been in a position to write the prescription that night, and so it could only have been legally written by a doctor. However, the signature did not match that of any of the doctors who might have attended a patient in the ward on that night shift.

The panel noted that in Witness 14's witness statement and in her oral evidence, she stated the use of the word 'nocte' is a nursing term and not generally used by doctors. Further Witness 14 told the panel that when Miss Callon was questioned during the first internal investigation interview on 30 August 2018, she denied that it was her handwriting on Patient A's prescription chart, but during the second internal investigation interview on 1 April 2019, she gave different evidence and said that she may have written the word *'nocte'*.

The panel noted that Miss Callon said in her response form that she had '*never given morphine that was not prescribed by a doctor.'* However, in the light of all the evidence

referred to above, the panel determined that, on this occasion, Miss Callon did write the prescription of a single dose of morphine on Patient A's prescription chart during the night shift of 28 July 2018. The panel determined that on the balance of probabilities Miss Callon also wrote the signature on Patient A's prescription chart when she was not qualified to do so.

The panel therefore found this charge proved on the basis that Miss Callon wrote the entire prescription, including the signature, and did not merely amend it to add the date and / or the word *'nocte'.*

Charge 1.2

> 1. On the night shift of 28 July 2018:
> 1.2. Administered morphine to Patient A when it was not clinically justified in that:
> 1.2.1 You did not carry out any, or any sufficient, assessment of patient A's pain needs;

This charge is found proved

In reaching this decision, the panel took account of the Witness 1 and Witness 12's respective written statements and oral evidence.

The panel also considered the controlled drugs book entry of 28 July 2018 and Patient A's patient's care notes on 28 July 2018.

The panel noted that the controlled drugs book shows that Miss Callon had administered morphine to Patient A on the 28 July 2018 night shift. Witness 12 who worked alongside Miss Callon on the 28 July 2018 night shift, confirmed that he had seen Miss Callon administer morphine to Patient A on the 28 July 2018 night shift.

The panel heard from Witness 2, Witness 6 and Witness 14 amongst others, regarding the need for pain assessments to be completed and recorded prior to administering *"as required"* or *"once only"* medications and on the first occasion

that a controlled drug is administered under a regular prescription. Witnesses were clear that a registered nurse must complete a pain needs assessment and record this in the patient's care notes, following administration of the drug, as a clear record of the reason for administration.

The panel was unable to identify any such entry in the patient's care notes in respect to Patient A's pain needs. The panel is satisfied that, had Miss Callon carried out any assessment of Patient A's pain needs, she would have made an entry in the patient's care notes recording this. The panel therefore found this charge proved.

Charge 1.2.2

1. On the night shift of 28 July 2018:
1.2. Administered morphine to Patient A when it was not clinically justified in that:
1.2.2 You did not consult a doctor

This charge is found proved

In reaching this decision, the panel took account of the Witness 7's written statement and oral evidence. Witness 7 confirmed that he was the on-call junior doctor on the 28 July 2018 night shift and he stated that he was not involved in attending or prescribing morphine to Patient A. He was not aware of any other doctors attending the ward that night. In an email of 13 August 2018 he stated '*I have not run into any other doctors...that night while on B4'*. Further, Witness 6 confirmed in his evidence that the Trust conducted investigations by looking at the signature of all of the doctors on duty on the 28 July 2018 night shift, who might have attended ward B4. The Trust was not able to match any of those doctors to the signature on the prescription.

The panel determined that, on the balance of probabilities, this charge is therefore found proved.

Charge 1.2.3

1. On the night shift of 28 July 2018:
1.2. Administered morphine to Patient A when it was not clinically justified in that:
1.2.3 You did not first administer a milder analgesia.

This charge is found proved

In reaching this decision, the panel took account of the Witness 4's statement and oral evidence, together with Patient A's prescription chart (which was found by Witness 4 discarded and torn up in the confidential waste bin for shredding).

The panel considered that in Witness 4's statement she stated that paracetamol was prescribed to Patient A as seen on the prescription chart, however there are no entries on the chart stating that paracetamol was administered. Further, the panel noted that no other milder analgesia was administered according to the chart. The panel therefore found this charge proved.

Charge 1.3

1. On the night shift of 28 July 2018:
1.3 Failed to record in Patient A's notes the reason for administration of morphine on the night shift of 28 July 2018.

This charge is found proved

In reaching this decision, the panel took account of Patient A's care notes which shows there is no reason recorded against the morphine being administered to Patient A. The panel also considered that it had heard from multiple witnesses who stated that the reason for once only medication administration should always be recorded on the patient care notes.

The panel determined that Miss Callon failed to do what would have been expected of her as a registered nurse. The panel therefore determined that this charge is found proved.

Charge 1.4

1. On the night shift of 28 July 2018:
1.4 Failed to record the time the morphine was administered to Patient A on the night shift on the prescription sheet.

This charge is found proved.

In reaching this decision, the panel took account of the prescription chart (sheet) and noted that there is nothing on the chart indicating the specific time that morphine was administered to Patient A. The panel accepted the evidence of Witness 14 that it would be in accordance with good practice for the time of any administration of a controlled drug to be recorded in the prescription chart (sheet).

The panel therefore determined that this charge is found proved.

Charge 1.5

1. On the night shift of 28 July 2018:
1.5 Tore up Patient A's inpatient prescription chart.

This charge is found proved.

In reaching this decision, the panel took account of the witness statements and oral evidence of Witness 1, Witness 2 and Witness 4. The panel heard from Witness 1 who confirmed that he was on duty and reported that Patient A's prescription chart had gone missing. The panel also heard from Witness 4 who testified that the prescription chart was found by her torn up and disposed of in the

confidential waste bin and from Witness 2 who had stuck the prescription chart back together.

The panel considered the oral evidence of Witness 4 who stated that one should never tear up a patient prescription chart and further, even if a drug were to be discontinued the prescription chart should never be disposed of because it forms part of the patient's record.

The panel also heard from Witness 14 in her oral testimony who stated that if a patient's prescription chart were to have been destroyed it would be *'illegal'.*

The panel was of the view that whilst there is no direct evidence to show that Miss Callon had torn up the chart, and other people had access to both the chart and the confidential waste bin, Miss Callon was the only person to have good reason to destroy the chart, in that she was attempting to conceal the unauthorised writing of the prescription.

The panel therefore determined that on the balance of probabilities, it is more likely than not that it was Miss Callon who tore up Patient A's prescription chart. The panel therefore found this charge proved.

Charge 1.6

1. On the night shift of 28 July 2018:
1.6 Put Patient A's torn inpatient prescription chart in the confidential waste bin on Ward B4.

This charge is found proved.

In reaching its decision, the panel determined that having found Charge 1.5 proved, for the same reasons it follows that Miss Callon did dispose of Patient A's prescription chart as she was the only person likely to benefit from this action. The panel therefore found this charge proved.

Charge 2

2. Your actions at charge 1.1 were dishonest in that you were by so doing representing that morphine had been properly prescribed or the prescription properly amended.

In reaching this decision, the panel considered the guidance in the legal test for dishonesty, as set out in the case of *Ivey.* The panel also took account of Witness 3 and Witness 7's respective written statements and oral evidence.

Witness 3, a handwriting expert, confirmed that the writing with the possible exception of the signature, on the Patient A's prescription chart was Miss Callon's. The panel's decision under charge 1.1 is that Miss Callon also wrote the signature on the prescription chart. The panel considered Witness 7's oral testimony when he stated that sometimes nurses in practice may write down a drug in anticipation of a doctor prescribing it, however other nurses would not and in any event, the panel has found that this did not happen in this case.

The panel was of the view that Miss Callon was a trained nurse of many years, who would have known that only prescribers can legally write a patient's prescription on the prescription chart. The panel noted that Miss Callon did not put her own name on the prescription chart nor did she sign it to say that she had administered the morphine. The panel determined that Miss Callon knowingly created a mark on the prescription chart to represent that it was not her who had written the prescription but someone authorised to do so.

The panel noted that, when interviewed in the internal investigations conducted by the Trust, Miss Callon changed her explanation of the prescription, saying first that it had been written while the patient was in ward B2, and later that she might have written the word *'nocte'*. This is inconsistent with the prescription being written in Miss Callon's handwriting and suggests she was fabricating the source of the prescription, as the panel has found to be the case. The panel determined that

ordinary people would consider that Miss Callon's actions were dishonest in that she was purporting that the prescription had been written by someone entitled to prescribe.

The panel determined that the both limbs of the test in *Ivey* have been met. It determined that Miss Callon knew what she was doing. It determined that her conduct would be regarded as dishonest by the standards of ordinary decent people. The panel therefore found this charge proved.

Charge 3

3. Your actions at charge 1.5 and/or 1.6 were dishonest in that you sought to conceal that you had written or amended the prescription.

This charge is found proved.

In reaching its decision, the panel determined that having found Charges 1.5 and 1.6 proved, that Miss Callon both tore up Patient A's prescription chart and disposed of it in the confidential waste bin, it follows that this charge is also proved. The panel determined that Miss Callon sought to conceal that she had written on Patient A's prescription chart, knew what she had done was wrong, and determined to dispose of the evidence, by first removing the chart from the patient's bedside notes and tearing it up, then placing it in the confidential waste bin, the contents of which she knew would, in normal circumstances, be shredded.

The panel determined that Miss Callon's actions in this regard would be regarded as dishonest by the standards of ordinary decent people. The panel therefore found this charge proved.

Charge 4.

4. Administered morphine to Patient F on 11.01.2018 at about 21:30 and/or 12.01.2018 at about 21:00 when it was not clinically justified in that:

4.1 You did not carry out any, or any sufficient, assessment of patient F's pain needs;

4.2 You did not administer a milder analgesia first;

4.3 All doses of morphine received by Patient F on Ward B4 were given under your care.

These charges are found not proved in relation to the morphine administered on 11 January 2018 at about 21:30

In reaching this decision, the panel had regard to the disciplinary hearing notes included in the evidence provided by the NMC. It heard from Witness 8 that he asked Witness 14 about Patient F's records and in the hearing notes it is documented that he asked *"can it be clarified who the prescriber is?".* Witness 14 confirmed that it could. The panel understands this to mean that the prescription was authorised by someone who was entitled to prescribe, even though Witness 3 confirmed that it was Miss Callon's writing on the prescription chart. In view of this, the panel considers that Patient F must have been seen by the doctor who signed the prescription. Therefore the administration of morphine to Patient F was clinically justified and therefore charges for 4.1, 4.2 and 4.3 are all found not proved.

These charges are found not proved in relation to the morphine administered on 12 January 2018 at about 21:00.

In reaching this decision, the panel had regard to Patient F's patient notes. The panel were of the view that there are serious doubts as to whether the dose of morphine was ever administered to Patient F on this date. Patient F's patient care notes indicate that the patient was recorded as being deceased at 20:30 on 12 January 2018, which was prior to 9pm when Miss Callon recorded that she had administered morphine to Patient F. Furthermore, the prescription chart confirms

that paracetamol was administered at 19:15 on 12 January 2018. The patient was unresponsive at 19:30, and that doctors were in attendance. Patient F's time of death was recorded to be before 9:00pm. In these circumstances, the panel was not satisfied that morphine was administered to Patient F at 21:00 on 12 January 2018, therefore this charge cannot be proved.

The panel therefore found charges 4.1, 4.2 and 4.3 not proved in respect of the morphine administered on 12 January 2018 at about 21:00.

Charge 5

5 Failed to record in Patient F's notes a rationale in Patient F's notes for the administration of morphine on one or more of the following occasions:

5.1 11/01/2018 at about 9:30pm;

This charge is found proved.

In reaching this decision, the panel had regard to Miss Callon's entries at 04:00am on Patient F's patient care notes dated 12 January 2018. It noted that intravenous medications recorded were given by Miss Callon. The panel also took account of the numerous witnesses who explained in oral evidence that when a first dose of a required prescription or a controlled medication is being administered, the expectation of a nurse is that the administration should be recorded specifically. As Miss Callon had not recorded any rationale for the administration of this medication noting a reference to a pain score, Miss Callon had failed in her duty.

The panel therefore found this charge proved.

Charge 5

5 Failed to record in Patient F's notes a rationale in Patient F's notes for the administration of morphine on one or more of the following occasions:

5.2 12/01/2018 at about 9pm.

This charge is found not proved.

In reaching this decision, the panel had regard to Patient F's patient notes. The panel were of the view that there are serious doubts as to whether the dose of morphine was ever administered to Patient F on this date. Patient F's patient care notes indicate that the patient was recorded as being deceased at 20:30 on 12 January 2018, which was prior to 9pm when Miss Callon recorded that she had administered morphine to Patient F. In these circumstances, the panel was not satisfied that morphine was administered to Patient F at 21:00 on 12 January 2018, so Miss Callon was not under a duty to record a rationale for such an administration. The panel determined therefore that this charge cannot be proved.

Albeit that this charge is not found proved, the panel noted that the analysis of the Controlled Drug book by witness 6 confirmed that the registrant had signed to confirm withdrawing the Morphine from the Controlled drug book and had signed Patient Fs prescription chart to confirm that she had administered the morphine.

Charge 6

6. Failed to record the administration of morphine to Patient F in the nursing notes on one or more of the following occasions:

6.1 On 11/01/2018 at about 9:30pm;

This charge is found proved.

In reaching this decision, the panel had regard to and Miss Callon's notes at 04:00am on Patient F's patient care notes recorded for the night shift of 11 January 2018. It noted that the patient care notes state *'intravenous medications...*

were given' , however it was of the view that this is not a specific description of the administration of morphine. The panel also took account of the numerous witnesses who explained in oral evidence that when a first dose of a required prescription or a controlled drug medication is being administered, rather than a regular prescription, the expectation of a nurse is that the administration and rationale for administration should be recorded specifically.

The panel therefore found this charge proved.

Charge 6.2

6. Failed to record the administration of morphine to Patient F in the nursing notes on one or more of the following occasions:
6.2 On 12/01/2018 at about 9pm;

This charge is found not proved.

In reaching this decision, the panel had regard to Patient F's patient care notes. The panel were of the view that there are serious doubts as to whether this dose of morphine was ever administered. The panel considered that Patient F's patient care notes indicates that the patient was recorded as being deceased at 20:30 on 12 January 2018, therefore Miss Callon was not under a duty to record the administration of morphine to Patient F, and could not have failed in that duty. The panel therefore found this charge not proved.

Albeit that charge 6.2 is found not proved due to there being no duty to record the administration of morphine, the panel noted that the analysis of the Controlled Drug book by witness 6 confirmed that the registrant had signed to confirm withdrawing the Morphine from the Controlled drug book and had signed Patient Fs prescription chart to confirm that she had administered the morphine.

Charge 7

7. Administered morphine to Patient D when it was not clinically justified in that you did not carry out any, or any sufficient, assessment of Patient D's pain needs on one or more of the following occasions:

7.1 15 May 2018 at about 23:10;

This charge is found proved.

In reaching this decision the panel had regard to Patient D's prescription chart and patient care notes. The prescription chart confirms the administration of morphine as charged. The panel also took account of Witness 14's written statement and oral evidence. Witness 14 testified that she had seen Patient D's observation sheets and noted that no pain score was present on 15 May 2018 at about 23:10.

The panel determined that there was no evidence put before it to show that a sufficient pain assessment was undertaken on 15 May 2018 at about 23:10 in respect to Patient D by Miss Callon. The panel therefore determined that this charge is proved.

Charge 7.2

7. Administered morphine to Patient D when it was not clinically justified in that you did not carry out any, or any sufficient, assessment of Patient D's pain needs on one or more of the following occasions:

7.2 16 May 2018 at about 04:30;

This charge is found proved.

In reaching this decision the panel had regard to Patient D's prescription chart and patient care notes. The prescription chart confirms the administration of morphine as charged. The panel also took account of Witness 14's written statement and oral evidence. Witness 14 testified that she had seen Patient D's observation sheets and noted that no pain score was present on 16 May 2018 at about 04:30.

The panel determined that there was no evidence put before it to show that a sufficient pain assessment was undertaken on 16 May 2018 at about 04:30 in respect to Patient D by Miss Callon. The patient care notes show an entry by Miss Callon at 03:30 on 16 May 2018 but the patient care notes show no further entries for that shift. The panel determined that the morphine administered to Patient D was not clinically justified. The panel therefore determined that this charge is proved.

Charge 7.3

7. Administered morphine to Patient D when it was not clinically justified in that you did not carry out any, or any sufficient, assessment of Patient D's pain needs on one or more of the following occasions:

7.3. 17 May 2018 at about 01:30.

This charge is found proved.

In reaching this decision the panel had regard to Patient D's prescription chart and patient care notes. The prescription chart confirms the administration of morphine as charged. The panel also took account of Witness 14's written statement and oral evidence. Witness 14 testified that she had seen Patient D's observation sheets and noted that no pain score was present on 17 May 2018 at about 01:30.

The panel determined that there was no evidence put before it to show that a sufficient pain assessment was undertaken or recorded in the patient care notes on 17 May 2018 at about 01:30 in respect to Patient D by Miss Callon. The panel determined that the morphine administered to Patient D was not clinically justified. The panel therefore determined that this charge is proved.

Charge 7.4

7. Administered morphine to Patient D when it was not clinically justified in that you did not carry out any, or any sufficient, assessment of Patient D's pain needs on one or more of the following occasions:

7.4 31 May 2018 at about 00:35.

This charge is found proved.

In reaching this decision the panel had regard to Patient D's prescription chart and patient care notes. The prescription chart confirms the administration of morphine as charged. The panel also took account of Witness 14's written statement and oral evidence. Witness 14 testified that she had seen Patient D's observation sheets and noted that no pain score was present on 31 May 2018 at about 00:35.

The panel determined that there was no evidence put before it to show that a sufficient pain assessment was undertaken by Miss Callon on 31 May 2018 at about 00:35 in respect to Patient D. The panel determined that the morphine administered to Patient D was not clinically justified. The panel therefore determined that this charge is proved.

Charge 8

8. Did not record a reason for the administration of morphine to Patient D on one or more of the following occasions:

8.1 16 May 2018 at about 04:30;

This charge is found proved

In reaching this decision the panel had regard to Patient D's patient care notes and prescription chart. The panel noted an entry made on the patient care notes on 16 May 2018 at 03:30 which stated, *'appeared to be unsettled ? in pain prn morphine given to good effect'.* There is no subsequent entry on the patient care notes for that shift which covered the administration of morphine at 04:30. The panel therefore determined that Miss Callon did not record a reason for the

administration of morphine to Patient D on 15 May 2018 at about 04:30. The panel therefore find the charge proved.

Charge 8.2

8. Did not record a reason for the administration of morphine to Patient D on one or more of the following occasions:
8.2 17 May 2018 at about 01:30;

This charge is found proved.

In reaching this decision the panel had regard to Patient D's patient care notes and prescription chart. The panel noted an entry made on the patient care notes on 17 May 2018 at 5am, which states that '*analgesia as prescribed'* was given, however there is no specific mention of morphine shown in the notes. The panel therefore determined that Miss Callon did not record a reason for the administration of morphine to Patient D on 17 May 2018 at about 01:30. The panel therefore found this charge proved.

Charge 8.3

8. Did not record a reason for the administration of morphine to Patient D on one or more of the following occasions:
8.3 31 May 2018 at about 00:35

This charge is found proved.

In reaching this decision the panel had regard to Patient D's patient care notes and prescription chart. The panel noted an entry made on the Patient D's patient care notes on 31 May 2018 at 06:00 *'medication given via NG'.* The panel noted that there was no entry on Patient D's care notes and no evidence put before the panel that refers to morphine or to a reason why morphine was administered to Patient D.

The panel therefore determined that Miss Callon did not record a reason for the administration of morphine to Patient D on 18 May 2018 at about 00:35. The panel therefore found this charge proved.

Charge 9

9 Did not record the administration of morphine to Patient D in the ~~patients notes~~ **nursing notes** on one or more of the following occasions:
9.1 17 May 2018 at about 01:30

This charge is found proved.

In reaching this decision the panel had regard to Patient D's patient care notes. The panel noted an entry made on Patient D's patient care notes on 17 May 2018 at 05:00. The panel determined that there was no reference in these patient care notes to morphine being administered to Patient D on 17 May 2018 at about 01:30.

The panel therefore determined that Miss Callon did not record the administration of morphine to Patient D on 17 May 2018 at about 01:30 in the patient care notes. The panel therefore found this charge proved.

Charge 9.2

9 Did not record the administration of morphine to Patient D in the ~~patients notes~~ **nursing notes** on one or more of the following occasions:
9.2 31 May 2018 at about 00:35

This charge is found proved.

In reaching this decision the panel had regard to Patient D's patient care notes. The panel noted an entry made on Patient D's patient care notes on 31 May 2018

at 06:00. The panel determined that there was no reference in these patient care notes to morphine being administered to Patient D on 31 May 2018 at about 00:35.

The panel therefore determined that Miss Callon did not record the administration of morphine to Patient D on 31 May 2018 at about 00:35 in the patient care notes. The panel therefore found this charge proved.

Charge 10

10 Administered morphine to Patient E when it was not clinically justified to do so in that you did not carry out or record any, or any sufficient, assessment of Patient E's pain needs on one or more of the following occasions:

10.1 11 April 2018 at about 21:45

10.2 12 April 2018 at about 02:25

These charges are found not proved.

In reaching this decision the panel took account of Witness 14's written statement and oral evidence. It also had regard to Patient E's patient care notes and controlled drugs book. The panel noted that the controlled drugs book shows morphine was administered by Miss Callon to Patient E on 11 April 2018 at 21:45 and on 12 April 2018 at 02.25 which was part of the same shift. Despite this, there is no entry on the prescription chart for the administration on 11 April 2018, and the NMC has not provided any explanation for the absence of such an entry. The panel noted that Miss Callon had written on Patient E's patient care notes at 03:40, *'I asked if she was in pain and she said she was so analgesia given',* although it does not detail the extent of pain Patient E was in. The panel is of the view that the entry in the patient care notes at 03:40 probably covers both administrations of morphine during that shift. The notation of *'I asked if she was in pain and she said she was so analgesia given',* was confirmed by Witness 14 as 'sufficient' to be an assessment of pain needs.

The panel therefore found this charge not proved in its entirety.

Charge 11

11. Did not record the administration of morphine to Patient E in the ~~patients' notes~~ **nursing notes** on one or more of the following occasions:

11.1 11 April 2018 at about 21:45 with respect to the dose;

This charge is found proved.

In reaching this decision the panel took account of Witness 14's written statement and oral evidence. It also had regard to Patient E's prescription chart, patient care notes and controlled drugs book. The panel noted two entries in the controlled drugs book under Miss Callon's signature, one for 21:45 on 11 April 2018 and one for 02:25 on 12 April 2018. The panel has been provided with a prescription chart relating to Patient E which contains two separate entries for morphine, one of which includes no administration of the drug and the other includes a single administration on 12 April 2018 of 2.5ml at 02:30. The charge alleges that Miss Callon did not record the dosage of an administration of morphine on the nursing notes at about 21:45 on 11 April 2018. However, no evidence has been provided to the panel to suggest that there is any duty to record such a dosage on a patient's nursing notes in addition to the record that should be included on the patient's prescription chart. Therefore, the panel finds this charge proved as a matter of pure fact, but will not take this finding into account in deciding on the issues of misconduct and impairment.

Charge 11.2

11. Did not record the administration of morphine to Patient E in the patients' notes on one or more of the following occasions:

11.2 12 April 2018 at about 02:25.

This charge is found proved.

In reaching this decision the panel took account of Witness 14's written statement and oral evidence. It also had regard to Patient E's patient care notes and controlled drugs book. The entries in the patient's care notes on 12 April at 03:40 record that *'analgesia given',* there is no specific mention of morphine being administered which would be expected as this is an *'as required'* prescription.

The panel therefore found this charge proved.

Charge 12

12 Administered morphine to Patient G at about 23:45 on 5 March 2018 when it was not clinically justified in that:
12.1 There was no prescription recorded on the patient's drug chart

This charge is found not proved.

In reaching this decision the panel took account of Witness 8's written statement and oral evidence. It also had regard to Patient G's notes. Witness 8's statement records that during the internal investigation, he had asked Witness 14 in relation to Patient E, *'was the dose [of morphine] on the chart'* and the answer from Witness 14 was *'no'.* However, the prescription chart in relation to Patient G was not provided to the panel in evidence. The panel was provided with the controlled drugs book which shows that the administration of morphine to Patient G was second checked by another nurse. Furthermore various witnesses have attested that a second checker would have checked the chart therefore a prescription would have been in place at the time of the administration of morphine to Patient G. The panel therefore found this charge not proved.

Charge 12.2

12 Administered morphine to Patient G at about 23:45 on 5 March 2018 when it was not clinically justified in that
12.2 You did not carry out or record, any, or any sufficient assessment of Patient G's pain needs.

This charge is found not proved.

In reaching this decision the panel took account of Witness 8's written statement and oral evidence. It also had regard to Patient G's patient care notes. The panel noted that there is an entry on Patient G's patient record on 5 March 2018 at 19:00 however there was nothing recorded after that time on that date. The panel determined that it would be impossible to say what was in the notes after 19:00.

The panel was of the view that Miss Callon had documented symptoms that would relate to significant pain. It notes that she had also given good reason for the medication and she also noted the effect of the analgesia in that Patient G was *'agitated and settled following analgesia'.* The panel therefore determined that this charge is found not proved.

Charge 13.

13 Did not record in Patient G's notes
13.1 a rationale for the administration of morphine at charge 12.

This charge is found not proved.

In reaching this decision the panel took account of Witness 8's written statement and oral evidence. It also had regard to Patient G's patient care notes. The panel determined that Miss Callon did record a rationale for administering morphine on the patient care notes. The panel was of the view that she recorded that the patient was *'...aggressive, hitting out at staff'* and was *'settled following analgesia'.* The panel determined that this charge is found not proved.

Charge 13.2

13 Did not record in Patient G's ~~notes~~ **nursing notes.**
13.2 the administration of morphine at charge 12

This charge is found proved.

In reaching this decision the panel took account of Witness 14's written statement and oral evidence. It also had regard to Patient G's patient care notes. The panel determined that Miss Callon did not document the administration of morphine in Patient G's patient care notes, in that she had only indicated that an '*analgesia was given'.* The panel therefore determined that this charge is found proved.

Charge 14.1

14 Administered morphine to Patient I on 4 June 2018 when it was not clinically justified in that:
14.1 You did not carry out, or record any, or any sufficient assessment of Patient I's pain needs.

This charge is found proved.

In reaching this decision the panel took account of Patient I's patient care notes. It determined that there is no mention of the administration of morphine to Patient I in Patient I's patient care notes on 4 June 2018, or any mention of Patient I's condition relating to pain. The panel is satisfied that, had Miss Callon carried out an assessment, she would have recorded something in the patient care notes, but as she did not make any record of an assessment, the panel has concluded that she did not carry out any assessment. The panel therefore found this charge proved.

Charge 14.2

14 Administered morphine to Patient I on 4 June 2018 when it was not clinically justified in that:

14.2 You did not administer a milder analgesia before administering the morphine.

This charge is found proved.

In reaching this decision the panel had regard to Patient I's patient care notes. The panel determined that whilst Paracetamol was prescribed as a milder analgesia on 4 June 2018, morphine was administered without paracetamol being administered first. The panel therefore found this charge proved.

Charge 17

17. Failed to record in Patient I's nursing notes that morphine had been administered on 4 June 2018.

This charge is found proved.

In reaching this decision the panel had regard to Patient I's patient care notes. The panel took account that there was no note of morphine being administered to Patient I on 4 June 2018. It therefore determined that Miss Callon failed to record the administration of morphine to Patient I and therefore found this charge proved.

Charge 18.1

18. In relation to Patient C:

18.1 Failed to document a pain score and/or a rationale for administering morphine on 22 July 2018 at about 05:00 and/or about 23:10.

This charge is found proved.

As it relates to the 23:10 22 July 2018 element only of this charge, the panel had regard to Patient C's patient care notes. The panel took account that there was no documentation in the patient care notes that record a pain score or a rationale for administering morphine to Patient C. The panel also noted that this was a once only prescription for morphine and in line with the Hospital's nursing practice, it would be expected that the reason for the morphine being administered to be noted. The panel therefore found this charge proved.

Charge 18.2

> 18. In relation to Patient C:
> 18.2 Failed to record the administration of morphine at about 05:00 and/or about 23:10 on 22 July 2018 in the ~~patient notes~~ **nursing notes.**

This charge is found proved.

As it relates to the 23:10 22 July 2018 element only of this charge, the panel had regard to Patient C's patient care notes and the controlled drug book. The panel took account that there was no documentation in the patient care notes that records the administration of morphine to Patient C. The panel therefore found this charge proved.

Charge 18.3

> 18. In relation to Patient C:
> 18.3 Failed to record why it was necessary to call a doctor to prescribe morphine on 22 July 2018.

This charge is found proved.

In reaching this decision the panel had regard to Patient C's patient care notes and prescription chart. The panel noted that there was no reason given in the patient care notes as to why the doctor was called to prescribe the morphine to

Patient C. The panel also noted that there was no mention of pain recorded on Patient C's patient care notes and further as to why it was necessary for morphine to be administered. The panel therefore found this charge proved.

Charge 18.4

18. In relation to Patient C:
18.4 Failed to administer the prescribed paracetamol and/or co-codamol before administering morphine.

This charge is found not proved.

In reaching this decision the panel had regard to Patient C's patient care notes and prescription chart. The panel also took account of the written statements and oral evidence of Witness 1 and Witness 6. The panel was of the view that, whilst it heard testimony from Witness 1, who took over from Miss Callon on the day shift of 23 July 2018, who stated that paracetamol had not been administered, the panel noted that paracetamol is shown as having been administered on Patient C's prescription chart on 22 July 2018 at 21.50. The panel determined that it preferred to rely on the written evidence on Patient C's the prescription chart. The panel therefore found this charge not proved.

Charge 18.5

18. In relation to Patient C:
18.5 Failed to dispose of the ampule of morphine into the sharps bin.

This charge is found not proved.

In reaching this decision the panel took account of the written statement and oral evidence of Witness 1. The panel noted that Witness 1, who was the nurse who administered the morphine with Miss Callon. In Witness 1's oral testimony he said that he thought that Miss Callon had held on to the ampule of morphine rather

than disposing of it immediately. However, when questioned by the panel, Witness 1 said that he did not see what happened to the ampule and could not be certain whether it was disposed of or not. The panel did not find this to be sufficient evidence to prove the charge. The panel therefore found this charge not proved.

Charge 19

19 On an unknown date in July 2018, after administering morphine to Patient M failed to dispose of the wastage/ampule in the sharps bin.

This charge is found not proved.

In reaching this decision the panel took account of the written statement and oral evidence of Witness 1. The panel noted that Witness 1 was the nurse who helped Miss Callon to administer morphine to Patient M. The panel took account that Witness 1 stated that he did not see the Miss Callon dispose of the ampule. Witness 1 further stated that Miss Callon said that she had thrown the ampule into the sharps bin on the ward. However, Witness 1 told the panel that he did not see this happen and then checked the sharps bin that she claimed she disposed of it in by looking through the narrow gap in the bin and he could not see the ampule. The panel determined that it did not consider this evidence sufficient to prove the charge, because Witness 1 was clearly not with Miss Callon at all times and cannot confirm that the ampule was definitely retained by Miss Callon. Further, the panel was of the view that it is unlikely that looking through the slot in the sharps bin would give a clear view of all of the contents within it. The panel therefore found this charge not proved.

Charge 20.1

20 Administered morphine to Patient H on 25 December 2017 when it was not clinically justified in that:
20.1 You did not carry out, and/or record any assessment, or any adequate assessment, of the patient's pain needs;

This charge is found proved.

In reaching this decision the panel took account of Witness 8 and Witness 14's respective written statement and oral testimony. It also had regard to the controlled drugs book. The panel noted that the administration of morphine is documented in the controlled drugs book but noted that Patient H's prescription chart for that day had not been exhibited as evidence. It also heard oral testimony from Witness 14 who stated that the second checker of the administered morphine had confirmed that she had seen the prescription chart. The panel considered that despite the absence of the original prescription chart, there is sufficient evidence before it to prove that the morphine was administered. The panel noted that Patient H's notes that were documented by Miss Callon did not record any assessment of pain or any mention of his pain needs. Further, the panel noted that Witness 8 confirmed that during the investigation meeting, he obtained confirmation that there was no pain score recorded anywhere in the patient care notes. The panel therefore this charge found proved.

Charge 21

> 21 Failed to record in Patient H's nursing notes that morphine had been administered on 25 December 2017.

This charge is found proved.

In reaching this decision the panel took account of Patient H's patient care notes written by the Miss Callon at 02.45 and 7.30 on 26 December 2017 and the prescription chart. It also had regard to Witness 14's written statement and oral evidence. Witness 14 informed the panel that these notes were the only notes made by Miss Callon relating to Patient H during that shift. Patient H's patient care notes state that '*all IV medications taken as prescribed'.* The panel noted that this note does not confirm that the morphine medication was administered.

The panel had regard to the new replacement prescription chart created on 26 December 2017 (the previous chart had gone missing), which did not show a regular morphine dose prescribed for Patient H. The panel considered that the morphine prescribed on 25 December 2017 would have been prescribed as a once only dose, and therefore the administration of that dose should have been recorded specifically in Patient H's patient care notes. The panel therefore determined that this charge is found proved.

Charge 22

> 22 Administered morphine to Patient J on 9 June 2018 when it was not clinically justified in that:
> 22.1 You did not carry out, and/or record any assessment, or any adequate assessment, of the patient's pain needs.

This charge is found proved.

In reaching this decision the panel took account of the respective written statements and oral evidence of Witness 6 and Witness 8. It also had regard to the controlled drugs book and Patient J's patient care notes. The panel noted that the administration of morphine is shown in the controlled drugs book as an injectable dose and in the patient care notes, Miss Callon has written '*medication taken as prescribed'.* The panel were of the view that it was not sufficient as this was an *'as required'* prescription and therefore should have been recorded in the patient care notes. The panel noted that Witness 8 had confirmed in his witness statement that there was no pain score recorded for Patient J. It also noted that Witness 6 confirmed that there was no mention of Patient J being in pain, and as this was the first dose of morphine, the reason for the administration of morphine along with a pain score and pain needs should have been recorded. The panel therefore determined that this charge is found proved.

Charge 22.2

22 Administered morphine to Patient J on 9 June 2018 when it was not clinically justified in that:
22.2 You did not administer a milder analgesia before administering the morphine.

This charge is found proved.

In reaching this decision the panel had regard to the prescription chart and Patient J's patient care notes. Patient J's prescription chart shows a prescription for co-codamol as an *'as required'* prescription. The panel noted that there is no administration of co-codamol recorded on the prescription chart or in the Patient J's patient care notes. The panel therefore determined that this charge is found proved.

Charge 23

23 Failed to record in Patient J's nursing notes that morphine had been administered on 9 June 2018.

This charge is found proved.

In reaching this decision the panel had regard to the prescription chart and Patient J's patient care notes. The panel noted that Patient J's prescription chart shows a prescription for morphine and that is was an *'as required'* prescription. The panel was of the view that it would be expected that the patient care notes would reflect this if morphine had been administered to Patient J. However, this was not recorded in the patient care notes. The panel therefore determined that this charge is found proved.

Charge 24

24 Recorded in the Controlled Drugs Register that the morphine booked out for patient J on 9 June 2018 was an injectable dose to be administered subcutaneously when:

24.1 It was prescribed to be taken orally;

This charge is found proved.

In reaching this decision the panel took account of Witness 6's written statement and oral evidence. It also had regard to the controlled drugs book, the prescription chart and Patient J's patient care notes. The panel noted that in the controlled drugs book morphine was dispensed as an ampule – as an injectable dose. Miss Callon had recorded that the morphine dose was administered orally, however, the controlled drugs book records indicates that an injectable dose was recorded and taken from the controlled drugs store and administered by the Miss Callon. The prescription chart also appears to show that morphine was prescribed as an oral dose because the dose is consistent with an oral dose.

The panel noted that Witness 6 explained in his witness statement that,

> *'The strength of the morphine syrup in use on the ward was 10mg in 5ml, with a 5ml dose of syrup containing 10mg of morphine. This directs that the doctor wanted the medication to be given as a mixture in a syrup form. The route written on the prescription is 'PO' which is an abbreviation for 'per os' (a Latin term meaning to be given by mouth). The dose was 2.5ml which is the dose volume and the normal way to prescribe this medication.'*

The concern is that the drug dose was prescribed as 2.5ml for the oral dosing with syrup but Miss Callon in the controlled drug register has written 2.5mg implying that it was given subcutaneously.

The panel was of the opinion that the prescription was altered by Miss Callon to show an alternative method of administration to justify her withdrawing the injectable dose from the controlled drugs store. The panel therefore determined that this charge is found proved.

Charge 24.2

24. Recorded in the Controlled Drugs Register that the morphine booked out for patient J on 9 June 2018 was an injectable dose to be administered subcutaneously when:
24.2 It was recorded on the prescription chart as being given by the oral route.

This charge is found proved.

In reaching this decision the panel took account of Witness 6's written statement and oral evidence. It also had regard to the controlled drugs book, the prescription chart and Patient J's patient care notes. The panel noted that in the controlled drugs book it was dispensed as an ampule – so as an injectable dose. Miss Callon had recorded on the prescription chart that the morphine dose was administered orally, however, the controlled drugs book records that an injectable dose was recorded, taken from the controlled drugs store and administered by the Miss Callon. The panel determined that Miss Callon recorded the dose as being administered orally which is inconsistent with the controlled drugs book records. The panel therefore determined that this charge is found proved.

Charge 25

25. Failed to record the administration of morphine to Patient B at approximately 04:45 on 19 July 2018 on the prescription chart.

This charge is found proved.

In reaching this decision the panel had regard to Patient B's patient care notes and the controlled drugs book. It noted that the controlled drugs book shows the withdrawal of morphine on 19 July 2018 at 04.45 by Miss Callon. However, it also noted that there is no corresponding entry on the prescription chart recorded by the Miss Callon. The panel therefore determined that this charge is found proved.

Charge 26

26. On 17 July 2018 administered morphine to Patient B when it was not

clinically justified to do so in that you did not carry out and/or record any or any adequate assessment of Patient B's pain needs.

This charge is found not proved.

In reaching this decision the panel took account of Witness 14's oral evidence and had regard to Patient B's patient care notes. The panel noted that Patient B's patient care notes record for the night shift on 17 July 2018 made at 05:35 on 18 July 2018 that, *'Breathing appears difficult so given PRN subcutaneous morphine with good effect'.* The panel also noted that Witness's 14 oral evidence, she confirmed that this is a sufficient and '*fairly descriptive'* record. Further, the panel also noted that Miss Callon also noted in Patient B's patient care notes of 18 July 2018, that two separate prescriptions should be made – one for pain and the other for breathing. The panel considered that as the notes indicate that morphine was administered for breathing, it determined that the that the morphine administration was clinically justified. The panel therefore determined that this charge was found not proved.

Charge 27

27. Failed to document the administration of morphine to Patient B in the nursing notes on 17 July 2018.

This charge is found not proved.

The panel determined that on the basis that it has found charge 26 not proved. It determined that Miss Callon did record that morphine had been administered. The panel therefore determined that this charge was found not proved.

Charge 29

29. Administered morphine to Patient K on 18 July 2018 when it was not clinically justified in that there was not a clear clinical indication that morphine was required.

This charge is found not proved.

In reaching this decision the panel took account of Witness 14's oral evidence and had regard to Patient K's patient care notes and prescription chart. The panel noted that Patient K's patient care notes dated 19 July 2018 made at 02:00 states: *'...difficulty breathing... given PRN morphine with good effect'.* The panel also noted that the prescription chart is written to administer Morphine *'as and when'* for pain or shortness of breath. During her oral evidence and when questioned by the panel about her written statement which said that she was not clear whether morphine was required for Patient K, Witness 14 said that she was now not sure why she had written that, having re-read Patient K's patient care notes. The panel was of the view that Patient K's patient care notes justify the administration of morphine on the basis of shortness of breath, which is consistent with the prescription. The panel therefore found this charge not proved.

Charge 30.2

30. On unknown dates in or around 2018 wrote and/or amended part or parts of one or more of the following prescriptions or purported prescriptions:
30.2 A prescription for Patient F dated 11 January 2018

This charge is found proved.

In reaching this decision the panel took account of Witness 3's written statement and oral evidence. The panel has considered and adopted the evidence of Witness 3 who indicated that the evidence albeit limited is that Miss Callon is more likely than not to have been responsible for writing all but the signature on the prescription for Patient F dated 11 January 2018. The panel therefore found this charge proved.

Charge 31

31. Your actions at charge 30 above were dishonest in that you intended that one or more of those parts appear to be written by someone else and/or to be genuine parts of a prescription, when you knew they were not.

This charge was found not proved.

In reaching this decision the panel took account of Witness 7, Witness 8 and Witness 9's respective written statements and oral evidence. The panel did not consider that the NMC has met the burden of proof to prove this charge of dishonesty.

Whilst the panel has found charge 30.2 proved by adopting the evidence of Witness 3 the handwriting expert, it did not find that the signature on the prescription was written by Miss Callon. During the hearing, the panel heard from numerous witnesses who confirmed that the expectation is that a nurse should not write any part of a prescription. However, Witness 7 in his oral evidence confirmed that although it should not happen, on occasion, nurses do pre-fill prescription charts in anticipation of a doctor arriving and signing off the prescription. The panel were of the view that this could be a feasible alternative explanation to dishonesty.

The panel has reviewed evidence before it provided by the NMC which included the disciplinary hearing notes for Miss Callon dated 6 August 2019. It recorded Witness 8 had asked a series of questions relating to each patient including the question *"Can it be clarified who the prescriber is?"*, to which Witness 14 answered *"yes"* in respect of the prescription for morphine for Patient F. This was in contrast to the answer given in relation to the other 10 patients where the response from Witness 14 was *"no"* for two of the patients and *"No suspicions re prescriber"* for the other eight patients' prescriptions. Accordingly, the panel is of the view that the disciplinary hearing notes confirm that a prescriber was clarified and therefore

whilst Miss Callon wrote the other parts of the prescription, the NMC has not met its burden of proof that this was done dishonestly, as a prescriber was subsequently asked to sign and confirm the prescription and did so. The panel therefore found this charge not proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Miss Callon's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

The panel, in reaching its decision, has recognised its statutory duty to protect the public and maintain public confidence in the profession. Further, it bore in mind that there is no burden or standard of proof at this stage and it has therefore exercised its own professional judgement.

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, Miss Callon's fitness to practise is currently impaired as a result of that misconduct.

NMC's submissions on misconduct and impairment

Miss Quinton-Carter provided the panel with written submissions on misconduct and impairment. She also made oral submission, in which she directed the panel to specific paragraphs within 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code). She identified where, in the NMC's view, Miss Callon's actions amounted to misconduct, as follows: *1.2, 4, 8, 10.1 10.2, 10.3, 10.5, 13.2, 13.3, 18.1, 18.2, 18.3, 19, 20.1 and 20.2.* Miss Quinton-Carter referred to *Roylance and the General Medical Council* which indicates that misconduct is a word of

general effect involving some act or omission which falls short of what would be proper in the circumstances, and also to *Calhaem and GMC* [2007] EWHC 2606 (Admin), which states that misconduct indicates a serious breach which suggests, that the relevant healthcare professional's fitness to practise is impaired.

Miss Quinton-Carter submitted that the facts found proved by the panel in this case do amount to misconduct in a number of areas, all of which she submitted are breaches of the NMC code of conduct. Miss Quinton-Carter noted that charge 11.1, was found technically proved on the facts, but it is not a charge that would be considered at this stage of the proceedings.

Miss Quinton-Carter submitted that the most serious charges found proved in this case are charges 2 and 3. She submitted that honesty and integrity are fundamental tenets of the nursing profession. The panel has found that Miss Callon was dishonest in relation to the completion of the prescription of morphine for Patient A and then concealing that she had completed that prescription by disposing of it.

Miss Quinton-Carter submitted that it is the NMC position that the dishonesty in this case is serious. Not only did Miss Callon write a prescription for a patient for whom it was not prescribed when she was not qualified to do so, it was a prescription for a controlled drug morphine, an opiate, at the very top the pain relief ladder, when no milder analgesia had been administered first. She submitted that Miss Callon then tore up Patient A's prescription chart, which is a legal document, and threw it in the confidential waste bin in an attempt to conceal what she had done, knowing that the contents of that bin would likely be shredded, increasing the likelihood of it never being discovered.

The panel has also found numerous failings in terms of record keeping, Miss Quinton-Carter submitted that these failings are serious. The NMC would suggest that Miss Callon's records do not inform other members of staff what has been administered to a patient, or why, or explain why such strong pain relief was required. Miss Quinton-Carter suggested that in many instances, the panel would recall where a patient had not required such pain relief previously.

Miss Quinton-Carter submitted that on many occasions Miss Callon administered morphine to patients where it was not clinically justified. In one instance, Miss Callon altered a prescription to show an alternative method of administration in order to justify withdrawing an injectable dose of morphine from the controlled drug store. She submitted Miss Callon had a predisposition towards the administration of morphine to patients, and a predisposition towards injectable administration, even where an oral route had been prescribed.

Miss Quinton-Carter therefore submitted that Miss Callon's actions as proven, fall far short of what would be expected of a registered nurse. She told the panel that it would recall from the evidence from many witnesses that Miss Callon is an experienced and popular nurse. One witness specifically noted he was delighted at being told he would be working the night shift with her on Ward B4. She submitted that colleagues and patients should rightly expect that controlled drugs are being administered safely and justifiably and that the corresponding records are accurate.

Miss Quinton-Carter submitted that the public would expect a nurse to act with honesty and integrity. They would expect a nurse to uphold the reputation of the nursing profession and to not administer, let alone prescribe, medication that was not clinically justified.

As a result, she submitted that numerous parts of the Code have been breached. As follows: 1.2, 4, 8, 10.1, 10.2, 10.3, 10.4, 10.5,13.2,13.3, 18.1,18.2 18.3, 19, 20.1 and 20.2.

Miss Quinton-Carter invited the panel to take the view that the facts found proved amount to misconduct.

With regards to impairment, Miss Quinton-Carter submitted that a finding is necessary in this case, on the ground of public protection and also in the wider public interest. She referred the panel to relevant case law including *Ronald Jack Cohen v General Medical Council* [2008] EWHC 581 (Admin) and Dame Janet Smith in her Fifth Shipman report

as endorsed by Mrs Justice Cox in the leading case of Council for Healthcare Regulatory Excellence v (1) NMC (2) Grant [2011] EWHC 927 (Admin).

Miss Quinton-Carter submitted that it is the NMC's position, that Miss Callon is unequivocally impaired on the basis of three of the four limbs of Dame Janet Smith's test of impairment, namely limbs two, three and four are engaged in respect of the dishonesty concerning Patient A. She also submitted that limb one could be said to be engaged in this case although, no harm was caused directly to patients by Miss Callon's actions, there were a number risks present in the context of particular patients she was responsible for treating. She submitted that Miss Callon through her actions placed patients at unwarranted risk of harm.

Miss Quinton-Carter submitted that Miss Callon is an experienced nurse of almost 20 years. She submitted that Miss Callon frequently administered morphine when it was not clinically justified to do so and neglected to document this properly or in some cases at all. On one occasion, she went so far as to prescribe it herself and then attempt to destroy and conceal the evidence.

Miss Quinton-Carter submitted that the panel may wish to consider whether Miss Callon's conduct can be remediated. She submitted that it is the NMC's position that it does not appear that Miss Callon has continued to work in any capacity since resigning from the Hospital. She submitted that Miss Callon has been subject to an interim suspension order since July 2019 and so has been unable to work in a nursing capacity. She submitted that there is no evidence of Miss Callon undertaking any training or course.

Miss Quinton-Carter noted from the outset that Miss Callon has made some concession in reference to her inadequate record keeping. She submitted that whilst the panel may consider that the bulk of the conduct, such as the inappropriate drugs administration and inadequate record keeping is remediable, there is no evidence of any attempt being made by Miss Callon to address these concerns. She submitted there is no evidence of Miss Callon showing any remorse for her past misconduct.

Miss Quinton-Carter submitted that in some instances it was not a case of Miss Callon's notes not being thorough, but instead being incredibly vague. For example, she wrote the word analgesia rather than morphine. She submitted that it would have been far clearer to colleagues coming to care for the patient afterwards had she written morphine and although Miss Callon said she was busy it would not have taken her more time. Further, in some instances, there were no entries in the notes at all.

Miss Quinton-Carter submitted that dishonesty is hard to remediate which the panel may find presents a risk of repetition in this case. She told the panel to bear in mind the age of this case and that Miss Callon, who has no prior regulatory findings in her name, has indicated to the NMC that she does not intend to return to practise as a nurse.

Miss Quinton-Carter submitted that Miss Callon appears to accept no responsibility for her actions in respect of the morphine administration, and she has not demonstrated an understanding or appreciation of the risks placed upon patients in her care. Nor does there appear to be any acknowledgement as to why this might be problematic for patients or colleagues.

Miss Quinton-Carter submitted that there is no evidence of any kind of insight, reflection acceptance or remorse by Miss Callon as to the seriousness of her failings in this case. She submitted that there is a clear public interest in the regulator taking action when nurses falsify and destroy any patient documentation, but also when they take it upon themselves to administer strong pain relief when it is not clinically justified and not recording accurately even where it might have been.

Miss Quinton-Carter submitted that honesty is a bedrock of the nursing profession and to be dishonest in and of itself would and should lead to a clear finding of impairment in this case, in order to uphold standards and maintain public confidence in the profession.

Miss Quinton invited the panel to make a finding of impairment in this case on the grounds of public protection and otherwise in the wider public interest.

The panel heard and accepted the advice of the legal assessor who directed the panel to relevant case law and legal authorities applicable in this case, including *Roylance v. GMC* [2000] 1 AC 311, *R (on the application of Remedy UK Ltd) v. GMC* [2010] EWHC 1245 (Admin.), *Preiss v. General Dental Council* [2001] 1 WLR 1926, *GMC v. Nwachuku* [2017] EWHC 2085 (Admin), *PSA v. GMC and Hilton* [2019] EWHC 1638, *Cohen v. GMC* [2008] EWHC 581), *R (on the application of Remedy UK Ltd) v. GMC* [2010] EWHC 1245 (Admin.), *CHRE v. NMC and Grant* [2011] EWHC 927 Dame Janet Smith's Fifth Shipman Report and *Schodlok v GMC* [2015] EWCA Civ 789.

Decision and reasons on misconduct

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council* which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

When determining whether the facts found proved amount to misconduct, the panel had regard to the terms of the Code in making its decision.

The panel was of the view that Miss Callon's actions did fall significantly short of the standards expected of a registered nurse and that her actions amounted to a breach of the Code. Specifically:

'1 Treat people as individuals and uphold their dignity
To achieve this, you must
1.2 – make sure you deliver the fundamentals of care effectively

8 Work cooperatively
To achieve this, you must:

8.2 - maintain effective communication with colleagues
8.3 - keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff
8.5 - work with colleagues to preserve the safety of those receiving care

8.6 - share information to identify and reduce risk

10 Keep clear and accurate records relevant to your practice
This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records. To achieve this, you must:

10.1 – complete all records at the time or as soon as possible after an event, recording if the notes are written sometime after the event

10.2 – identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need

10.3 – complete all records accurately and without any falsification

10.5 – take all steps to make sure that all records are kept securely

13 Recognise and work within the limits of your competence
To achieve this, you must, as appropriate:

13.2- Make a timely referral to another practitioner when any action, care or treatment is required

13.3 - Ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence

18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations
To achieve this, you must:

18.1 prescribe, advise on, or provide medicines or treatment, including repeat prescriptions (only if you are suitably qualified) if you have enough knowledge of that person's health and are satisfied that the medicines or treatment serve that person's health needs

18.2 keep to appropriate guidelines when giving advice on using controlled drugs and recording the prescribing, supply, dispensing or administration of controlled drugs

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice
To achieve this, you must:

19.1 - take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place

20 Uphold the reputation of your profession at all times
To achieve this, you must:

20.1 keep to and uphold the standards and values set out in the Code
20.2 act with honesty and integrity at all times
20.4 keep to the laws of the country in which you are practising'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. It bore in mind that the areas of concern related to matters that are arguably of varying degrees of seriousness.

The panel considered the legal assessor's advice that there might be some charges that were not serious enough to amount to misconduct on their own but which might be regarded as misconduct when considered together with other charges of a similar nature. The legal assessor suggested that charge 18.1 might be one such charge. However, the panel concluded that charge 18.1 was in fact serious enough to amount to misconduct on its own, because it contained two elements. Firstly, failing to document a rationale for administering morphine on the stated date; secondly, failure to document a

pain score. The first of these two elements the panel considers to be serious enough to amount to misconduct on its own.

The panel went on to consider the issue of relative seriousness in relation to the allegation that Miss Callon did not first administer a milder analgesia before administering morphine to patients. This allegation is made in four separate charges, namely charges 1.2.3, 4.2, 14.2, 22.2, in relation to four different patients. Had this been an single isolated incident involving only one patient the panel might not have found that it amounted to misconduct. However, it occurred on four separate occasions within a seven month period and in the wider context of the facts found proved, the panel consider them to be misconduct.

The panel considered the element of dishonesty in charges 2 and 3. It determined that this is serious and involved the writing of a prescription when Miss Callon was not authorised to do so. Miss Callon represented to another nurse (who signed the controlled drugs book and checked the administration of the morphine to Patient A at Miss Callon's request) that the morphine had been properly prescribed. She then tried to conceal the prescription she had written by tearing up the chart and disposing of it in the confidential waste bin.

The panel determined that the records are relied upon by other professionals in providing continuity of care, and its removal therefore carried the risk of patient harm. Miss Callon's actions were a serious departure from that which is expected of a nurse. The panel therefore determined that this amounts to misconduct.

The panel took account of Miss Callon's response form where it noted in her response that she accepted the concern to *'documentation and record keeping'* but commented *'I did not have time to write notes as thoroughly as I would have liked as I spent my hours of work caring for patients which I felt was more important at the time'*. The panel is not convinced by this response and does not accept this as a reason for her actions. The panel considers documentation of the assessment of patient's pain needs and the rationale for the administration of drugs as a basic requirement of the nurse when delivering care to a patient. Miss Callon's response shows that she has no insight into her misconduct. The panel also noted that Miss Callon stated that she worked on a very busy ward and was more often than not working alongside agency staff. However, the

panel heard no evidence that Ward B4 was understaffed at that time, or of any other extenuating circumstances that might have preventing a nurse recording the notes that were required. The panel find that being busy is a poor reason for Miss Callon's actions.

The panel noted that it had not heard from Miss Callon with regard to the allegations of dishonesty at all, except to claim in her response form that she had never administered morphine to a patient which had not been prescribed by a doctor. Having heard the evidence in this case, the panel rejects this claim in the light of its finding that the prescription, which is the subject of charge 1.1 including the signature, was in fact written by Miss Callon herself.

The Panel considered the matter in charge 24 in which it found Miss Callon had altered a prescription and administered the drug subcutaneously instead of orally as it was prescribed. The panel considered this matter as serious, as any amending or changing of a prescription chart by a nurse without authority or training to do so was beyond Miss Callon's scope of practice.

In light of the above the panel determined that, in relation to all the charges found proved against Miss Callon, her actions did fall seriously short of the conduct and appropriate standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Miss Callon's fitness to practise is currently impaired.

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* in reaching its decision. In paragraph 74, she said:

'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'

The panel determined that Miss Callon has not demonstrated or upheld proper professional standards and that faith in the profession would be damaged if nothing were done in relation to her conduct.

In paragraph 76, Mrs Justice Cox referred to Dame Janet Smith's "test" which reads as follows:

'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that S/He:

a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*

b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*

c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*

d) has in the past acted dishonestly and/or is liable to act dishonestly in the future.'

The panel determined that all four limbs of Dame Janet Smith's test of impairment are engaged in this case.

By administering morphine without assessment or appropriate prescription, Miss Callon did put patients at risk of harm and given Miss Callon's apparent lack of remorse or remediation, the panel were of the view that such actions would be likely to be repeated in future.

Actions relating to inappropriate administration of drugs and a failure to accurately record the administration of drugs and the rationale for administration, would not be seen as acceptable by members of the public and others and would bring the nursing profession into disrepute.

Miss Callon's dishonest actions breached the fundamental tenets of the nursing profession and the panel were not confident that Miss Callon would act any different in the future.

The panel bore in mind that the overarching objectives of the NMC; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions. The panel determined that a finding of impairment on public interest grounds is also required.

The panel determined that Miss Callon's dishonesty is not easily remediable. It has not seen any evidence of remediation or insight, nor that she has addressed her dishonesty in this case. The panel determined that it is likely that the conduct found proved would happen again.

In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds Miss Callon's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Miss Callon's fitness to practise is currently impaired.

On Thursday 11 May 2023, the hearing was adjourned part-heard due to lack of time to complete the hearing.

The hearing resumed on Thursday 7 September 2023.

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike Miss Callon off the register. The effect of this order is that the NMC register will show that Miss Callon has been struck-off the register.

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had careful regard to the Sanctions Guidance (SG) published by the NMC. The panel accepted the advice of the legal assessor.

Submissions on sanction

Miss Quinton-Carter outlined the NMC sanction bid for the imposition of a striking off order, if it was found Miss Callon's fitness to practise is currently impaired. She submitted that the only appropriate sanction in this case was one of a striking-off order on the grounds of public protection and also in the wider public interest.

Miss Quinton-Carter referred the panel to the SG in relation to dishonesty Reference: SAN-2 and to relevant legal authorities, including *Pillai v GMC* [2015] EWHC 305 Admin and *Parkinson v Nursing and Midwifery Council* [2010] EWHC 1898 (Admin). Miss

Quinton-Carter submitted that the law surrounding healthcare regulation makes it clear that a nurse who has acted dishonestly will always be at risk of being removed from the Register. She submitted that it is the NMC's position that the dishonesty in this case is serious.

She submitted that Miss Callon deliberately breached the professional duty of candour by, in effect, forging a prescription and then attempting to hide the fact that she had done so. This created a direct risk of harm to vulnerable patients in a ward which largely contained end of life and stroke patients. In relation to dishonesty, she submitted that the dishonesty in this case could technically be said to have been a one-off, however in the case of Miss Callon, it is against a backdrop of numerous medication administration errors in which prescription charts were either altered or patient notes either insufficiently completed or not completed at all. She further submitted that Miss Callon has not engaged with the NMC and therefore it cannot be said that she has shown any remorse for her actions. She submitted that in the absence of any evidence of remediation and no insight or remorse, the panel could take the view that there is a high risk of repetition based on the finding of dishonesty.

In relation to aggravating factors in this case, Miss Quinton-Carter submitted that the panel may wish to include a pattern of misconduct over a period of months, misconduct which put patients at risk of harm and lack of remorse and insight. She submitted that, in fairness to Miss Callon, whilst there is no specific mitigation in this case, she referred to the brief suggestion by Miss Callon to her [PRIVATE] around the time these incidents occurred. However she noted that no other information was ever provided. She also acknowledged Miss Callon's otherwise longstanding unblemished career.

Miss Quinton-Carter invited the panel to conclude that the only appropriate and proportionate sanction in this case is one of a striking off order.

The panel heard and accepted the advice of the legal assessor which included reference to the cases of *Tait v Royal College of Veterinary Surgeons (RCVS)* [2003] UKPC 34 (20 March 2003) and *Pillai.* The legal assessor also advised the panel that it

should decide the issue of sanction on the basis of the facts found proved, in the context of the cases cited and the relevant NMC guidance.

Decision and reasons on sanction

Having found Miss Callon's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had careful regard to the SG published by the NMC. The panel accepted the advice of the legal assessor.

The panel took into account the following aggravating features:

- Misconduct put patients at risk of suffering harm;
- No remorse and a lack of insight into failings;
- A pattern of misconduct over a period of months; and
- Dishonesty.

The panel also took into account the following mitigating feature:

- Practised for a number of years without any reported regulatory concerns.

The panel did consider the NMC's position in relation to potential mitigation based on Miss Callon's [PRIVATE] as indicated in her resignation letter of 27 January 2020. However the panel was unable to attach any weight to this factor as no further information was put before it and it was not highlighted at the time. The panel was of the view that it is incumbent on registrants to ensure they consider their [PRIVATE] is sufficiently good to practise unhindered.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case. The panel was of the view that Miss Callon had put patients at risk of harm and as such, the profession was brought into disrepute. The panel determined that it is a fundamental tenet of nursing practice to work in the best interest of patients at all times. In this regard the panel decided that it would be neither proportionate nor in the public interest to take no further action.

It then considered the imposition of a caution order but again determined that patients would be left at significant risk if Miss Callon's practice were not restricted. In addition, the panel determined that on public interest grounds an order that does not restrict Miss Callon's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Miss Callon's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Miss Callon's registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges found proved in this case. The misconduct identified involves dishonesty which in this case was not something that could be addressed through remediation or retraining. The panel was of the view that there is evidence of an attitudinal problems and given that Miss Callon has shown no insight and has not engaged with the NMC or these proceedings, patients would be put at risk if she were to continue to practise unrestricted. The panel concluded that the placing of conditions on Miss Callon's registration would not adequately address the seriousness of this case and would not protect the public.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that suspension order may be appropriate where some of the following factors are apparent:

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*
- *In cases where the only issue relates to the nurse or midwife's health, there is a risk to patient safety if they were allowed to continue to practise even with conditions; and*
- *In cases where the only issue relates to the nurse or midwife's lack of competence, there is a risk to patient safety if they were allowed to continue to practise even with conditions.*

The panel considered that the factors identified here were not applicable to this case. While only one charge of dishonesty has been found proved, the panel noted that in Charge 24, Miss Callon had altered a prescription without authority, and that the other charges related to assessment and documentation errors over a period of time. It was of the view therefore, that this case did not involve a single instance of misconduct. There has been no repetition because Miss Callon has not been practising, but given her lack of insight and her attitude towards the recording errors she made, it considers that there is real risk of repetition. Miss Callon's [PRIVATE] has not been formally cited as a reason for her conduct, nor is she considered to be lacking in competence. Further, she has stated that she wishes to be removed from the register, and the panel determined that the likelihood of her beginning to engage with the regulator, to facilitate her return to practice after a period of suspension, was minimal. The panel therefore determined that suspension was not an appropriate sanction.

In light of these circumstances, the panel did not consider that a period of suspension would be sufficient to protect the public or maintain public confidence in the nursing profession

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel noted that the serious misconduct found proved in this case is fundamentally incompatible with Miss Callon remaining on the register.

In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

Finally, in looking at a striking-off order, the panel took note of the following paragraphs of the SG:

- *Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*

- *Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?*

- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

The panel determined that Miss Callon's actions were a significant departure from the standards expected of a registered nurse, and are fundamentally incompatible with her remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Miss Callon's actions were serious and to allow her to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

Taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard

to the effect of Miss Callon's actions in bringing the profession into disrepute, by adversely affecting the public's view of how a registered nurse should conduct herself, the panel has concluded that nothing short of this would be sufficient in this case.

The panel considered that this order was necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered nurse.

This will be confirmed to Miss Callon in writing.

Interim order

The striking-off order cannot take effect until the end of the 28-day appeal period, or the conclusion of any appeal that is lodged. The panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Miss Callon's own interests until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Miss Quinton-Carter. She submitted that an interim suspension order for a period of 18 months should be made on the ground that it is necessary for the protection of the public and is otherwise in the public interest, in order to cover any appeal to be lodged and determined.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months. This order is for a period of 18 months in order to allow for the possibility of an appeal to be made and determined.

If no appeal is made, then the interim suspension order will be replaced by the striking - off order 28 days after Miss Callon is sent the decision of this hearing in writing.

That concludes this determination.